RESOLVING THE CAUSE OF PAIN

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A high index of suspicion may assist in the detection and resolution of pain often suffered silently.

DYSPAREUNIA is a common and distressing female sexual condition that remains under-reported and under-treated.

Female sexual dysfunction is highly prevalent (11%) and is associated with a negative impact on physical, psychological and overall quality of life.

This article provides an overview of dyspareunia and uses a typical case study to illustrate the benefits of a physiotherapeutic approach.

CAUSATION

Vaginismus and dyspareunia are often co-occurring and difficult to differentiate.

Vaginismus is characterised by difficulty with vaginal penetration and involuntary muscle contraction, whereas pain is the main diagnostic criteria for dyspareunia.

A best-practice approach encompasses a biopsychosocial model implemented by a multidisciplinary team.

Causation is multifactorial and involves cognitive, biological and psychosexual contributors, which may vary according to each stage of life.

Biological causes include infection, inflammation, hormonal, anatomical muscular and iatrogenic factors.

Dyspareunia can occur as a consequence of the oestrogen-lowering impact of menopause (naturally occurring or surgically induced) and breast feeding.

Psychosexual causes include depression, anxiety and history of sexual abuse, which can be exacerbated by mismatched libido, lack of intimacy, inadequate arousal and conflict.

CASE STUDY

Presentation: Isabelle was a 28-year-old nulliparous woman who presented to her GP with pain on intercourse.

She became sexually active at 19 and had always experienced dyspareunia, which she described as "like a knife" at penetration.

Initially, she considered this normal, but after nine years she was seeking treatment to be "better able to meet her husband's sexual needs".

They had not had penetrative sex for three years. Upon questioning, it became apparent she had experienced a poor level of sex education and was raised in a sexually repressed social environment.

Isabelle reported that she had recurrent vaginal thrush in her early 20s. She frequently used OTC treatments, which provided relief.

Isabelle also mentioned that Pap smears had always been painful and that she had never been able to use tampons.

She and her partner had tried lubricants, which made no difference to her pain. She also discussed her concerns about "not feeling like a real woman", and wanted to know "what is wrong" with her.

Diagnosis: Isabelle was referred for physiotherapy following a normal trans-abdominal pelvic ultrasound. She was unable to tolerate a trans-vaginal approach.

Assessment: Initial assessment involved patient education of pelvic anatomy, particularly pelvic floor muscles and discussion of the causes of vaginal pain.

With consent, a vaginal palpation of the pelvic floor muscles was performed to find vaginismus in the levator ani muscles, particularly on the left.

Treatment: Isabelle commenced a program including myofascial release and trigger point therapy by her physiotherapist as well as down-training (relaxation) exercises.

She was encouraged to avoid penetrative intercourse during treatment but to continue other forms of intimacy. Treatment also included the use of vaginal trainer cylinders (dilators), biofeedback and sexual education focusing on arousal.

After six treatments, Isabelle was encouraged to recommence intercourse after using her largest trainer and with appropriate lubricant (e.g. Sylk or olive oil) when she was pain free. She was discharged from physiotherapy with a maintenance pelvic floor program.

HIDDEN HURDLES

Treatment barriers include: unresolved vulval skin conditions, mental health issues, PTSD related to past trauma, relationship difficulties and difficulty engaging with the program (goals unmet by the patient), and inability to prioritise self-treatment.

It is important for GPs to be aware that women are often reluctant to mention dyspareunia.

There is, therefore, a need for an increased level of suspicion.

Indications include pain during routine vaginal examination or Pap smear.

If vaginismus is suspected or palpated, it usually requires physiotherapy treatment.

References at medobs.com.au

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